

**WISCONSIN MEDICAID
REQUEST FOR WAIVER OF PHYSICAL THERAPIST ASSISTANT AND
OCCUPATIONAL THERAPY ASSISTANT SUPERVISION REQUIREMENTS**

Wisconsin Medicaid requires certain information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Completion of this form is mandatory to receive a waiver of Wisconsin Medicaid's supervision requirements for therapy/therapist assistants as specified in HFS 105.27(2), 107.16(1), and 107.17(1), Wis. Admin. Code.

Instructions: Type or print clearly.

| | |
|--|---|
| Name — Billing Provider | Telephone Number — Billing Provider |
| Address — Billing Provider (Street, City, State, Zip Code) | Billing Provider's Wisconsin Medicaid Provider Number |

I request a waiver under HFS 106.13, Wis. Admin. Code, for services provided on and after August 1, 2000, for the following requirement:

- ☐ A Medicaid-certified physical therapist assistant under the direct, immediate, on-premises supervision of a physical therapist (HFS 107.16[1], Wis. Admin. Code).
- ☐ A certified occupational therapy assistant under the direct, immediate, on-premises supervision of a certified occupational therapist (HFS 107.17[1], Wis. Admin. Code).

Under this waiver, I understand that I am required to do the following:

- Continue to meet the Department of Regulation and Licensing (DR&L) standards for supervision of assistants who provide services to Medicaid recipients.
- Document this supervision by countersigning all entries in medical records, in accordance with HFS 106.02, Wis. Admin. Code.
- Maintain appropriate records regarding supervision, in compliance with DR&L requirements and with HFS 106.02, Wis. Admin. Code.

I understand that this waiver is automatically granted when Wisconsin Medicaid acknowledges receipt of this form. The waiver is effective until the direct, immediate, on-premises supervision requirement is revised through a change in the Wisconsin Administrative Code.

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| SIGNATURE — Provider | Date Signed |
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Send completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Retain a copy of this form for your records.